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ABSTRACT

This paper discusses ways parents influence the educational and emotional development of their handicapped children and how parent involvement in special education programs facilitates growth processes in these children. Research findings indicating the importance of the parent-child relationship and parenting styles are summarized. Program descriptions are presented and suggestions are given for implementing aspects of parent involvement in programs designed to meet the needs of handicapped children. Included are discussions of the desire for varied program approaches to meet individual parent-child needs; language delay and creative programming in the home; child abuse problems and solutions; severe emotional handicaps in children and how parents can help; the need to provide information for parents (on their children's handicapping conditions, on various types of programs and the theories on which they are based, and on mainstreaming possibilities) to help them make decisions as to the best placement for their children. Advantages of parent-to-parent models which provide opportunities for parents of handicapped children to talk and work together are discussed along with programs focusing on the prevention of childhood handicaps through parent education; educational resources for parents; and parental characteristics and behaviors which are likely to promote optimum development of handicapped children. (SE)

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Parent Involvement and the Development of Children with Special Needs [1]

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Parent involvement early in the development of handicapped children is a recent phenomenon. Not only were parents not usually involved early in activities to optimize a child's development, but often the advice was given to "come back in a few years. It is too early to tell. It is too early to do something as yet." So there were few programs for very young handicapped children, and even fewer efforts to involve their parents actively. What has happened to change this?

I believe that a deepening and pervasive, albeit slow, spread of child development concepts and knowledge has begun to result in changes in the treatment of children with special needs. There is a new awareness that the earlier one begins stimulation, enrichment, or optimization of the growth of an infant or young child, especially a handicapped child, the more chances one has to prevent potentially severe effects of a particular disability. Another and more recent contribution of child development theory and research has been that the parent is most admirably suited as a special teacher for any young child--but crucially so for the special child. Therapy programs may take place a few hours per week. Teachable moments abound in the home. The parent has far more opportunities

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to become a skilled observer both of present level of functioning and of the kinds of rewards that will best motivate the young learner in the home. Most importantly, the parent has a special loving-caring relationship with the child.

The Importance of the Parent-Child Relationship

Researches by Klaus and Kennell (1976), by Bell and Ainsworth (1972) and by T. Berry Brazelton (1975) have demonstrated the power of early loving attachment between parent and baby for ensuring optimal development of children. In infancy, loving and learning are inextricably intertwined. This is an important idea to understand if the ideal of working with handicapped infants from day one is to be carried out effectively. Parents then can be seen to be "natural choices" to further the learning careers of their infants. My own personal experience with infants from culturally disadvantaged families has impressed me with the importance of a loving attachment as a prime key to unlocking a baby's learning potential. In the day care setting, for example, we had one six-month old whose young mother was not well-attached to her baby. Months of loving care and prompt responsivity to the baby's needs by her special caregiver in the infant center paid off. The baby became emotionally more alert and brightened happily on seeing her caregiver. She also began to engage in imitative vocalization, patty-cake, and other developmental games in interaction with her caregiver. She had previously been totally unreceptive to such games.

Sroufe (1978) has recently urged us to consider parent-infant attachment as an organizational construct which promotes child

competence. He builds an eloquent case for regarding a strong positive parent-child bond as the basis for more mature problem-solving during the preschool period. Research indicates that insecurely-bonded infants show poorer adaptation to tool-using situations in their second year. Well-attached babies are less negativistic, less easily frustrated, have fewer temper-tantrums, and are better able to use an adult as a source of help (Matas, 1977). Since a handicapping condition per se may already involve much frustration for a child, the importance of building secure parenting attachments may be particularly critical for handicapped children. Nurturant parenting has long been found to promote higher achievements in normal children.

Parenting Styles

Research has shown that some parents do rather well and some are less adequate as teachers of their own children. These studies help us note the kinds of parenting behaviors that are more likely to be helpful to a young child's development.

Honig (1975) has summarized some of the literature relating to parenting skills. Process variables which relate to the kinds of developmental facilitation parents provide and their intellectual activity and expectations of the child turn out to be far more important than status variables such as income or education level of parents. How actively and adeptly parents encourage their children to develop is more important than their material circumstances in life. This is encouraging news. Particularly encouraging are the results of research on positive parenting practices as related to child competence. Carew and her colleagues

(1976) spent years observing the interactions of normal parents and babies at home. At three years of age the children differed greatly in their competence both on psychometric tests and in problem-solving situations in the home. What are the major differences that distinguished parents of more competent three's? Honig (1978, p. 30-32) has summarized a baker's dozen of these differences:

1. When babies were the most competent, the mother turned out to be a good organizer and arranger and shaper of infant experiences and routines.
2. Homes of competent infants had toys that were typical of a nursery school--crayons and papers and puzzles and such.
3. Competent children were allowed to help a lot with household chores- dusting, hammering, raking leaves, helping to sort laundry.
4. Fathers in the families of the competent babies spent more positive interaction time with their children. All the families were two-parent families, incidentally.
5. Competent children were allowed access to what we would call more messy and perhaps even slightly dangerous items. There were blunt scissors in the homes of these children. Parents allowed their toddlers to help with washing up dishes even though a puddle might have to be sponged up from the kitchen floor. Indeed, there is no one more enthusiastic at helping wash dishes than a two-year old. Have you ever watched a "two" wash dishes with soapsuds up to his shoulders?

6. Regular reading to infants daily. There are so many researchers now that confirm the importance of early regular reading for later cognitive competence. Reading (with expression, interest, change of voice tone, and conversing about the story) correlated with later intellectual achievements.
7. TV differences. In the most competent children's homes, TV was severely limited and supervised. The children could watch one hour of a program such as "Sesame Street." In the least competent infants' homes, children watched 6 hours a day if they wanted, and viewed any program.
8. Mothers of competent children modeled appropriate activities for the children. If the parents wanted a child to do something, they showed him how.
9. The mother was a good observer. She sort of kept an eye out to see where the child was at, developmentally, what the child was doing in which part of the house. The mother gauged her responses and activities according to her observations of the child's interests, abilities and temperament.
10. The mother praised, encouraged, suggested, permitted, and facilitated--she was a facilitator. Where the mother was highly restrictive and punitive, the child's competence was severely damaged. The children from such families were in the least competent group. Mothers of competent infants often participated with the child during activities.

11. Competent children's parents had firm, consistent household rules. They provided reasons for their rules.

12. The mothers of competent infants behaved as <u>teachers</u>. The mothers conversed, posed questions, transmitted information and helped their children to solve problems. They helped their children to understand what they didn't understand. If you remember, Smilansky (1968) in her classic study of socio-dramatic role play differences among advantaged and disadvantaged children, observed that few low-income parents see themselves as teachers. And, of course, parents are the most precious teachers of all.

13. The mother as dramatizer. Mothers of competent infants engaged in dramatic play. For example, one day the researcher arrived and found mother with her 16 month-old in the kitchen. Both had toy badminton rackets in their hands and were playing pretend badmnton. Did you ever play fantasy tea-parties with young children? Did you ever see your little one hiding in your closet among your clothes and say, "Where's Joan? I've lost Joan! What will Daddy say when he comes home? Where can Joan be?" All the while Joan, in full visibility in the closet, is entranced with joy at this pretend game.

Role playing games help promote cognitive competence. Other games and entertainments of these parents often had intellectual content. Entertainment by parents of less competent infants often involved just physical, rough and tumble play.

Programming for Parents of Children with Special Needs

We need varied approaches

Ways by which parents are involved may vary widely depending on the handicapping conditions and the needs of a child. The needs of a severely culturally deprived youngster who is motorically and perceptually intact differ pragmatically from the needs of a multiply handicapped, profoundly retarded boy, such as 11 year old Stephen. Mrs. Hosey (1973), Stephen's mother, has described movingly how Stephen is included in a loving family and how important each child of the family, including Stephen, is. A parent involvement program for profoundly retarded non-walking, non-speaking youngsters such as Stephen perhaps should be best carried out by providing supports for the family's loving care as well as provision of special facilities for the child during the day.

Many approaches and much flexibility are necessary. Working with parents will probably be most helpful to youngsters when we individualize our help to families just as we individualize our program for each handicapped child.

Some programs involve children in special education but with parental participation in the schooling. The Delayed Development Project in Stockton, California (Jew, 1974) is such a project. All infants under 18 months who have evidenced significant delays in development have a home-visiting teacher weekly. The home visitor works with the baby and offers suggestions to parents for stimulating the child. From 18 months of age, babies are bussed five mornings a week to participate in individual therapy and small group activities

in a classroom. Parents are asked to spend one morning a week in the school. To accomodate fathers, "Dad's Day" classes are held on Saturdays. Evening group meetings for parents are scheduled with a psychologist. "Parents support each other as they discuss their fears, hopes, anxieties, and problems" (Jew, 1974, p. 9). Thus, a variety of program efforts are constantly initiated to meet the needs of the families whose children are enrolled.

Language Delay and Creative Programming

Profound motor involvement of speech mechanisms may alert project personnel to seek for creative language teaching programs that parents can carry out at home. Bliss symbols and the Non-Slip (Non-Spoken Language Initiation Program) plastic-chip communication symbols may prove useful when children do not talk. Parents can learn to help their children to communicate with these innovative techniques. "Ordinary" speech therapy or otherwise "conventional" special education techniques may not always be the answer. Are we being creative enough to devise techniques and therapies that parents as well as professionals can comfortably carry out? Are there enough materials addressed to parents, so that, for example parents of speech-handicapped children can find answers to their questions (Eisenson, 1976).

Autistic children or distant children may have trouble processing visual and verbal stimuli at the same time. These children may be without eye or language contact and thus may present special challenges for parents and special educators.

An emotionally and verbally unresponsive child can be so frustrating to an adult. Many parents cannot bear the "rejection" such child behavior seems to imply. Some parents then move away emotionally from their child. Recently, Ameslan, American Sign Language, has been used successfully to help autistic youngsters learn to communicate their needs with each other and with adults (Offer, 1976). Social positive interactions are the rewards for learning the hand signals. Children can ask with their hands for adult help, for food, for a toy. Parents are being taught Ameslan so they can interact with and teach their children at home also. A mother teaches her child the sign for peanut. She shapes his hands with hers. She says and signs the word. When he succeeds in signing without physical prompting, she rewards him with a peanut and a delighted kiss. What a simple yet special joy for this parent. What a new world of social-personal skills opens for this child.

Child Abuse Problems

Children at risk and developmentally delayed due to abuse form a growing clinical population. A team approach with abusive parents has worked well in the AT-Risk Program in Tulsa, Oklahoma. A Social worker, a mental health nurse, and a public health nurse coordinated their efforts. Mothers are helped to become involved in feeding a failure-to-thrive infant. If the hospital alone has success in improving the child's physical condition, the parent may feel even lower self-esteem. This might increase the chances for further abuse. Primary prevention means that parents have to be the focus of a therapeutic effort to help families serve their function of nurturing the young. When

neglect or abuse has occurred, treatment must include the family or recurrence may be inevitable. In Kansas, a token-economy model has been used to help abusive parents learn positive child-rearing alternatives (Christopherson, et al., 1976).

Selma Fraiberg and her colleagues (1975) use a psychoanalytic kitchen-therapy approach to help mothers experience the depth of rage, fear and pain feelings inherited from their own disturbed childhood. Fraiberg feels that the alternately neglected and abused babies of these mothers can best be helped by reaching the deep parental feelings that underlie the maltreatment. Again, no one theory, no one system may be "best" for all families-or all helping professionals.

Severe Emotional Handicaps

Many children with severe enotional handicaps are in residential treatment centers. How can families be involved? Magnus (1974) has given us some good ideas to help ensure parental participation. If lack of transportation prevents a parent from visiting a child, for example, then the insitution should arrange for such a service. If parents cannot leave home, the institution can send a staff member to visit the home. Employers can be urged to give employees time off to visit the center. Parents can form a supportive long-distance telephone network with each other. Parents can be invited to participate in a weekly discussion group composed of parents with children in the same unit. Parents can be invited to come to meetings where staff members plan for and review a child's case. Parents, even hostile parents with destructive feelings toward their children, can be made to feel socially welcome at

the residential treatment center. Parents should be encouraged to observe how their child relates to others. Parents must be helped to understand their actions. Many parents may be unaware of how their former relationships contributed to the child's emotional handicap and anguish. The institution needs to take an "our" problem, not a "your" problem approach. Parents are encouraged to act out parenting roles with other children in the center. Finally, staff must move a family toward preventive problem-solving so that the child can return home and so that minor problems don't become major ones on the return. Discussion of choices, decisions, and sensitive areas can help families cope with the return home of the child form the treatment center.

Advice for Parents

Sometimes elaborate counseling or therapeutic techniques are not necessary. But parents may very well need information advice. A parenting program may then involve a concerted effort to explain to and to support a parent of a child with, for example, a deformed limb. Explanations and information are very important for parents of Down's Syndrome babies (Golden & Davis, 1974). In the past such parents were often misinformed as to their child's potential for leading a productive life within the family. Drs. Parmelee and Kopp at the University of California Medical School in Los Angeles have done a good deal to counsel parents of severely physically impaired infants. It is wonderful how ingenious the parent of a limbless toddler can become when a supportive program is available. For example, one parent of a thriving youngster, born limbless, played "catch" by having the child use his forehead to return the ball.

Integration or Mainstreaming

Many parents will want to help to make decisions about mainstreaming possibilities for their child. Many programs nowadays are recruiting developmentally delayed infants into special classes with the ultimate goal of preparing the child with active parental assistance for mainstreaming by kindergarten age. Other programs are deliberately integrating handicapped youngsters and normal children during preschool years although this may not be feasible in later years. Diane and William Bricker have provided integrated preschool experiences based on behavioral prescriptive principles where Down's Syndrome preschoolers and normal toddlers were integrated in classes. Parents actively participated in carrying out activities toward behavioral goals.

Parents of handicapped children will need to think about integration experiences for each individual case. Sometimes a parent is depressed at seeing how much further developed the "normal" peers are compared to his child. Sometimes a parent is proud of how his child copes so well in a mainstreamed setting.

Communities may want to consider creating parent advocacy centers (such as the Center in Human Policy in Syracuse, New York). Parents could use such a center as a resource for finding out about special educational placement and about integrated settings. Visits could be arranged to community facilities so that parents could learn first hand how such programs are being carried out. Parents need such a service to help them become more adequate decision makers for and with their handicapped children.

The Theory Behind a Program

Programs for handicapped children are usually modelled on one or another theoretical model, although some programs are eclectic. To guide a parent in choice of placement, programs should specify what kind of theoretical model they follow. Programs also need to describe whether they follow a model more rigidly or more flexibly. Some programs follow a behavioral-modification, task-analysis model very rigorously. In the Home-Center Model (Fredricks, Baldwin and Grove, 1974) a chart is given (p. 29) entitled "Task analysis of the dressing skill of removing pants, underpants." Steps are given in detail that the child shall push pants down to ankles, grab cuffs, and remove pants, when various amounts of adult help are at first given and, later, withheld. Self-help skills, toilet training and language acquisition programs are available for parents to conduct at home. The parent chooses a program, such as rote-counting, and carries out the small steps detailed in the program. Teachers model all steps and cues and degrees of precision required of a child in carrying out each step. The delivery of social and tangible reinforces is taught.

The Portage Project (Shearer, D. 1970, Shearer, MS., Weber, 1975) in Wisconsin, for children from birth to six years, is another program that is based on an S-R behavioral model. This project attempts to involve parents directly in the education of their child by teaching the parent "what to teach, what to reinforce, how to observe and record lists of behaviors" (p. 212). Operationally defined behavioral or

curricular goals are set. Small steps to meet each circumscribed goal are taught. One goal is set for parents each week. The parent is expected to practice the prescribed task 5 times per trial, 3 times per day. A typical prescription might be "hop on one foot without support."

Parents may feel more comfortable when models are thus behaviorally delineated. Other parents may become so involved in a task such as "child shall place piece down in puzzle" that they may not remember that solving a whole puzzle as a game or taking note that the puzzle when completed forms a puppy are larger goals very much to be desired.

Some parents may want to know more about the stages of sensorimotor and preoperational development in Piaget's theory. They might feel more comfortable devising their own means-ends or object permanence or seriation games with their own children. Some parents will be more concerned with the social-emotional development of their handicapped youngster. Such a parent might be given some of Erikson's writings to help clarify how basic trust, autonomy, and other positive emotional-social traits can be fostered by positive parenting practices.

Some parents may want to read descriptions of programs that have a combined theoretical approach. The Syracuse University Children's Center program for disadvantaged low-education families and their infants and young children based activities and processes of interaction on Piaget, Erikson and language development theorists (Honig, A., 1977). In this program, home visitors provided emotional support for parents. Home visitors modelled

and taught skills in optimizing infant competence. They brought information about nutrition, child development and positive communication processes to the home. They also helped parents utilize other community support systems and helped parents meet their own needs for personal growth, job training and education. Developmental day care was provided for the children as a supplement to the parenting outreach.

Parent-to-parent Models.

Hayden (1974) has reported on her program for handicapped children from birth to 18 years. Parents usually find that "among the many advantages of being trained in the center, rather than at home, is the opportunity to talk to and work with other parents of handicapped children. Those parents who have children with similar handicapping conditions often develop strong bonds of friendship and are appreciative of the gains made by all the children" (p. 12). Parents helping other parents may be one of the most effective ways a program can galvanize some parents to become more involved in the development and education of their handicapped child. Dr. Hayden does not use parent training packages. She emphasizes that individual parents have unique needs and problems.

Bassin and Drovetta (1976) have also reported that parent to parent contacts have been most successful in providing parent involvement in the development of developmentally disabled newborns who enter this program in St. Louis. Parents are trained as volunteers. Perhaps only parents who have reared handicapped children can honestly say "We've been there - can we help?" The objectives of this program are for parents to

work with new parents of handicapped infants to:

1) explain jargon-free about a given disability
2) assist in locating community resources
3) provide helpful hints on home training
4) share ideas about ways to tell relatives and friends about the disability
5) help new parents understand and accept their own attitudes and feelings about having a disabled child.

Children at Risk

Many programs are focusing on parent education and involvement particularly to prevent handicapping conditions such as retardation or failure to thrive. Hospital personnel and public health nurses need to plan more carefully with and for new parents to join parent-groups once the new baby and parent are home from the hospital. This effort to involve at-risk parents in programs with their babies and with other parents as possible will of course require the multi-disciplinary efforts of social workers, Child-Find programs, private physicians and others in addition to hospital pediatric out-patient clinic personnel. Too often, special educators have viewed thier role as "fixer-uppers" rather than team-workers to help prevent handicapping conditions whenever possible.

Parents are powerful and necessary allies (Kroth, 1978). They can be invaluable along with professionals as family tacticians and life-plan organizers to prevent damage, to promote optimal development. Preventative programs have a chance to offer available options for parents should special services become necessary. Parents can plan better for the

at-risk child when they understand and know what community programs are available. Aside from using such resources as a given program may suggest, parents themselves, when given skills, may enlist older siblings or grandparents as special educators of at-risk children to provide extra stimulation in loving and appropriate doses.

Resources for Parents

Programs for the handicapped need to serve as a clearinghouse on information that parents need. Suppose a baby has great difficulty in swallowing. Mueller's oral-pharyngeal stimulation techniques have been successfully used by Dr. Jones (1977, p. 131).

Suppose a child lies blind and inert in his crib. A program can supply information on the construction of a mobile that will provide responsive auditory stimulation every time the infant kicks the mobile. Bower, (1977) has found that when such an auditory mobile was installed and used, the blind baby, who "had never smiled in eight weeks of life, learned to kick and produce a change of sound; he smiled and cooed. Pleasure in problem solving will help a child grow not only in sensorimotor and intellectual competence but will also promote happiness" (Honig, 1978, p. 10).

Other ingenious ideas abound. Dr. Bernard Friedlander has devised Play Test equipment for infant cribs which will allow an infant by pressing a lever to produce lullabies or stories on tape.

Dr. Margaret Jones at UCLA has designed tactile books and activities to promote sensory experiences related to what the

parent or teacher is reading or describing for a blind child. Jones' Theraplay fun house promotes spontaneous activity, balance, and sociability. A separately enclosed environment is covered with resilient material so that an enormous bean-bag-bed effect is produced. Multiply handicapped children are safe to glide, slither and explore this environment and each other together. They need not fear injury if they fall or turn over on the gently inclined slope of this environment.

Not only physical equipment and interaction techniques but audiovisual materials should be made available for parents who want to know more. Bibliographies of reading materials for parents of exceptional children are available (1975). A media training program is available from Utah State (undated) and from Parents Magazine Films (1975).

Curricular guides can be used as aids. "Preschool learning activities for the visually impaired child" is published in Springfield Illinois (undated). Physical activities for handicapped children are suggested by Marx (1972).

EPSDT programs locally should be able to provide leads to audiovisual and reading materials.

Cartoon-like stick figures enliven four booklets by Mayer (1974, available from ERIC). These booklets are easy to read and make many aspects of language, learning, and emotional disabilities clearer to parents. ERIC has also published a Bibliography of materials for families of handicapped children.

TAPP materials are available from Atlanta, Georgia. Ingenious ideas are available such as putting jam on a child's

lips so that weak tongue and lip muscles can be strengthened by licking off the jam!

The Exceptional Parent is a magazine to which parents may want to subscribe. Their concerns are directly reflected in monthly articles such as Swirsky's (1977) "The Parent as Professional."

Some educators have written extensively to improve parent-teacher relationships and cooperation when exceptional children are in school (Gordon, 1975; Kelly, 1971; Kroth, 1975). Head Start (1976) will send an excellent pamphlet of helpful ideas for parents of children with special needs. Thus there are many materials and resources available to help parents of exceptional children learn more about their special child and how to cope. Program personnel need to develop generosity in sharing not only their expertise but their knowledge of such resources with the families they serve.

Skills Parents Will Need

Programs that involve parents of handicapped children are challenged to consider all the ways they can best support parents trying to optimize the development of a child. What characteristics and behaviors will help parents cope better?

1. Parents need flexibility. A parent must be able to plan ahead - and be able to un-plan when life situations or the child's condition make this a wiser course.

2. A parent needs observation skills. A parent must watch

for what a child can do. Note what motivates this child. Capitalize on the strengths of this special child; capitilize on his or her interest.

3. Challenge the child. A parent should try to build on present skills and motivate the child to the limits of his or her capabilities. Often special children are expected to be not only different but much less able. Haffner (1976) is a young college graduate born without arms or legs. He pays eloquent tribute to his parents who constantly challenged him to try: "The basic thing my parents did was just to let me experiment and to encourage me to go out and be Terry Haffner. They let me experience all the normal triumphs and tragedies of everyday neighborhood life. I was never smothered or kept inside or away from the action. I got snow inside my special boots and [illegible] mud and dirt and stones inside my artificial arms." (p. 15). A parent needs to help a child use the competence that is available. A child who has a motoric handicap may be eloquent at show-and-tell time. A blind youngster may be an excellent student of foreign languages and quickly grasp the nuances of different dialect patterns.

4. Meet the match in teaching new behaviors. Matchmaking is the skilled art of setting goals and problems neither blatantly too easy nor cruelly too hard for the child. Each rung up the developmental ladder requires keen use of observation skills and good understanding of child development. The parent can then adjust activities or goals so they really "match up" with the child's present level of attainments yet challenge

the child to move forward another step toward maturity - whether in self help skills, language skills, sociability skills, intellectual understandings, or motoric control.

5. A parent needs to nurture. Loving kindness, acceptance, and tenderness make all the difference. If the special child feels that he or she is truly O.K. to the parent, with the parent, for the parent - that child will be given a precious boost toward feeling comfortable about himself or herself. Haffner (1976) has written this about growing up with physical disabilities; "My story is a testament to my parents' surpassing strength and courage. It demonstrates what it can mean to grow up in a circle of genuine warmth and love, acceptance and giving." (p. 16).

6. Teach and reward imitation. A parent needs to be a good model. The slow child can be helped by a skillful parent to learn many behaviors just by watching a parent perform them slowly and clearly.

7. Manual guidance can help. Many times a handicapped child needs physical assistance to perform a task in the early stages of learning. A child may need help with pulling a pant leg over his shoe once he has pulled a trouser down to shoe level. At first a deaf child may need much help in molding his hands to learn correct signs. Early manual guidance plus clear verbal instructions can boost a child's confidence that the tasks struggled with are not insurmountable. With much practice the child will be able to do more and more on his own. As the child learns what the parent is teaching, the parent can phase out manual guidance gradually.

8. Use strong stimulation when necessary. Retarded infants should ideally receive more rather than less stimulation. Sometimes the parent needs to use exaggerated pleasure responses to arouse the child. Strong happy personality gestures and actions can elicit desired responses more during a lesson. Positive vigorous personal responses from a parent can be used to reward a child's learning. Positive contingent, salient rewards help a child try hard. Of course, optimal stimulation should never be confused with over-stimulation.

9. Discipline wisely. Severely retarded youngsters sometimes exhibit inappropriate behaviors such as head banging, eating dirt or poking their eyes. A parent can say "NO" sharply. A parent can distract a child decisively by engaging the child's body otherwise. Physical punishment should not be used. When "time out" is used as a discipline technique with retarded youngsters it should be reserved for clearly defined unacceptable or inappropriate behaviors such as assaultiveness. If time out is used indiscriminately, unwanted behaviors can even increase. The child may interpret this punishment as rejection and react by "acting out" more. Program personnel can carry out role playing assignments with parents to practice new discipline techniques such as distraction or making clear statements of household rules accompanied by explanatory gestures. Parents can be asked to practice giving contingent praise to reward a child's trying. Other positive discipline alternatives can be discussed with parents.

10. Parents need supports. Parents are people with needs for recreation, for husband-wife time together and for personal time. The needs of a severely retarded child, a hyperactive child, or an emotionally handicapped child for constant attention can be wearing for the most patient or talented parent. Programs can offer services to parents which give the parent a "breather." Special school classes, homemaker service, therapist visits may boost a parents' feeling that others care, that the parent is not alone. Programs can build a variety of services to support parents in their efforts to parent well. Parents themselves may be able to suggest ways they feel would give a boost to their ability to persevere.

Conclusion

Help for the handicapped child must be considered in the light of help for the family. As program personnel increase their ingenuity at involving parents as therapists and as teachers who are in a special loving relationship with the child, children will be better served. If serving handicapped children is the primary goal, then serving parents by involving them in programmatic efforts will better serve that primary goal.

References

A mediated training program for parents of preschool mentally retarded children. Instructional technology project, Logan, Utah: Utah State University Special Education, undated.

Bassin, J. and Drovetta, D. Parent Outreach. The Exceptional Parent, 1976, 6, 6-9.

Bell, S. and Ainsworth, M.D.S. Infant crying and maternal responsiveness. Child Development, 1972, 43, 1171-1190.

Bower, T.G.R. A primer of infant development. San Francisco: W.H. Freeman & Co., 1977.

Brazelton, T.B. Mother-infant reciprocity. In M.H. Klaus, T. Leger & M.A. Trause (Eds.) Maternal attachment and mothering disorders. Sausalito, California, Johnson Baby Products, 1975.

Carew, J.V., Chan, I. & Halfer, C. Observing Intelligence in young children. Englewood Cliffs, New Jersey: Prentice-Hall, 1976.

Christopherson, E.R., Kuehn, B.S., Grinstead, J.D., Barnard, J.D., Rainey, S.K., & Kuehn, F.E. A family training program for abuse and neglect families. Journal of Pediatric Psychology, 1976, 1, 90-94.

Eisenson, J. Is your child's speech normal? Reading, Massachusetts: Addison Wesley Publishing Co., 1976.

For Parents of Exceptional Children: A Bibliography. Talahasee, Florida: Department of Education, 1975.

Fraser, L. A cup of kindness: A book for parents of retarded children. Seattle, Washington: Bernie Straub Publishing Co., Special Child Publications, 1973.

Golden, D.A. & Davis, J.G. Counseling parents after the birth of an infant with Down's Syndrome. Children Today, 1974, 3, 7-11.

Gordon, S. Living fully: A guide for young people with a handicap, their parents, their teachers, and professionals. New York: John Day & Co., 1975.

Grim, J. (Ed.). Training parents to teach. University of North Carolina, Chapel Hill, N.C.: TADS (Frank Porter Graham Child Development Center), 1974.

Hafner, T. The cap and gown feeling. The Exceptional Parent, 1976, 6, 13-17.

Head Start. Parent Involvement: Focus on children with special needs. Washington, D.C.: Head Start, 1976.

Honig, A.S. Parent involvement in early childhood education. Washington, D.C.: The National Association for the Education of Young Children, 1975.

Honig, A.S. The Family Development Research Program, In B.M. Caldwell & D. Stedman (Eds.). Infant Education, Chapel Hill, N.C.: TADS, Suite 500,NCME Plaza, 1977.

Honig, A.S. A review of recent infancy research. Washington D.C.: Drigle Associates, 1978.

Hayden, A.H. A center-based parent training model. In J. Grim (Ed.). Training parents to teach: Four models. Chapel Hill, N.C.:TADS, 1974.

Hosey, C. Yes, our son is still with us. Children Today, 1973, 2, 14- 17.

Jew, W. Helping handicapped infants and their families: The delayed development project. Children Today, 1974, 3, 7-10.

Johnson, V.M. & Werner, R.A. A step-by-step learning guide for retarded infants and children. Syracuse, New York: Syracuse University Press, 1975.

Jones, M.H., Intervention Programs for Children under Three years Old,p.123-147. In B.M. Caldwell & D. Stedman (Eds.) In Infant Education, Chapel Hill, N.C.: TADS, Suite 55, NCME Plaza, 1977.

Kelly, E.J. Common sense in childraising: A special education approach. Denver, Colorado: Love Publishing Co., 1971.

Klaus, M.H. & Kennell, J.H. Maternal-infant bonding. St. Louis: C.V. Mosby Co., 1976.

Kroth, R.L. Communicating with parents of exceptional children: Improving parent-teacher relationships. Denver, Colorado: Love Publishing Co., 1975.

Kroth, R.L. Parents - powerful and necessary allies. Teaching Exceptional Children, 1978, 10, 88-91.

Magnus, R.A. Teaching parents to parent: Parent involvement in a residential treatment program. Children Today, 1974, 3, 25-27.

Marx, O.H. Physical activities for handicapped children in the home. Iowa City: The University of Iowa, 1972.

Matas, L. Mother-infant attachment: Implications for understanding the two year old. Unpublished doctoral dissertation. University of Minnesota, 1977.

Mayer, C.A. Understanding young children: Emotional behavior and development.

Understanding young children. Intellectual development and intellectual disabilities.

Understanding young children: Language development and language disabilities.

Understanding young children: Learning development and learning disabilities.
ERIC Clearinghouse on Early Childhood Education, Urbana, Illinois: 1974.

Offir, C.W. Visual speech: Their fingers do the talking. Psychology Today, 1976, 10, 73-78.

Parent Magazine Films. Even love is not enough: Children with handicaps (Filmstrip series). New York, N.Y.: Parent Magazine Films, 1975.

Perske, R. New directions for parents of persons who are retarded. Nashville, Tennessee: Abington Press, 1973.

Preschool learning activities for the visually impaired child: A guide for parents. Springfield, Illinois: Instructional Materials Center (undated).

Raifner, S. & Drouillard, R. Get a wiggle on: A guide for helping visually impaired children grow. Mason Michigan: Ingham Intermediate School District, 1975.

Shearer, D. et al. The Portage guide to early education: instructions and checklist. Portage, Wisconsin: Cooperative Educational Service Agency No. 12, 1970.

Shearer, M.S. & Shearer, D.E. The Portage Project: A Model for early childhood education. Exceptional Children, 1972, 210-217.

Sroufe, A. Attachment as an organizational construct. Child Development, 1977, 48, No. 4, 1184-1199.

Swirsky. The parent as professional: The Exceptional Parent. Boston, Massachusetts: Psy-Ed Corporation, 1977, 44-49.

Weber, S.J. et al. Portage guide to home teaching. Portage, Wisconsin: Portage Project, Cooperative Educational Service, 1975.